PRV – Outreach MediPASS Provider Agreements Processing

Purpose:

The purpose of this procedure is to process new MediPASS Provider Agreements. The Iowa Medicaid Patient Access to Service System (hereinafter referred to as MediPASS) is a primary care patient management system implemented in accordance with Title XIX of the Social Security Act and is subject to the provisions of the Iowa Administrative Code.

Identification of Roles:

Primary Role - This procedure will be performed by the Provider Education and Outreach team as well as the Provider Enrollment team.

Secondary Role – Customer Service Representatives will be cross-trained in MediPASS functions.

Performance Standards:

Increase MediPASS provider participation by five percent (5%) per year for each contract year, from base year. The base year is the 12-month period prior to the effective date of Iowa Medicaid Enterprise contract.

Path of Business Procedure:

Step 1: Outreach receives scanned image of MediPASS agreement via mailroom or OnBase.

a. An outreach member goes to OnBase PRV02 to retrieve MediPASS agreements.

Step 2: Outreach reviews the agreement for completeness, eligibility, and confirms the information with the provider's office (if necessary):

a. Is the provider one of the eligible provider types? (Doctor of Medicine (MD),Doctor of Osteopathic Medicine (DO), Advanced Registered Nurse Practitioner (ARNP), Nurse Midwife, Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC)
b. Is the provider's specialty type one of the 5 eligible for MediPASS? (General Practice, Family Practice, Internal Medicine, Pediatrics, Obstetrician /Gynecologist (OB/GYN)
c. Minimum hours regularly scheduled at this site? Must be at least 20 hours.
d. Does the provider perform primary care functions?
e. Is all of the required information completed on the Agreement including the following:
f. Maximum number of enrollees provider will accept (up to 1500 for single practitioners, 2400 for Rural Health Clinic or FQHC)
g. Any age restrictions a provider may request. For example: a Pediatrician may only see members from 0-17 years of age.
h. Any sex restrictions a provider may request (An OB/GYN generally requires that only females be enrolled.)

i. A provider must indicate if they are accepting "current members only" or will they accept random assignments.
j. Has the provider listed a 24-hour telephone number where members can call during the day to obtain instructions for care when the office is closed?
k. Has the provider indicated the counties in which they will serve members? The counties must be contiguous to the provider's county of residence.
l. If the provider was contacted to verify information, a general note is then placed on the application indicating the name of the person in the provider's office who confirmed the information and the date it was confirmed.

Step 3: Agreement complete, if Yes go to step 5. If No go to step 4.

Step 4: Agreement is pended and letter to provider for information.

Step 5: Staff updates OnBase.

a. Determine the proper provider legacy number by performing a name search in the Medicaid Management Information System (MMIS).
    1. Make sure the address on the agreement matches the address on MMIS.
b. Once number is determined, return to the agreement in OnBase.
c. On the right side on the OnBase screen, click on the icon named "Edit Provider Numbers".
d. A window will appear on the left side of the screen.
e. Enter the legacy provider number and NPI (if available) into the box provided.
f. Once the provider number is entered, then click on "Submit" at the bottom of this window.

Step 6. Determine if the Agreement is for the Iowa Wellness Plan or MediPASS based upon keywords. If it is for the Iowa Wellness Plan go to Step 8

Step 7: Enter the information from MediPASS agreement into the Provider Master File in MMIS.

a. Select application (9) Provider Subsystem form the Iowa Medicaid Management Information System on Line Applications (MMIS)
b. Enter option "C" in the Provider Master File to update the provider's record.
    1. This function can only be done by those staff members with special authority update MMIS.
c. Tab down to the provider number field and enter the provider's seven-digit Medicaid legacy number. Press Enter.
d. Tab to the "LANG" and enter values of (1) Spanish, (2) Bosnian, (3) Serb/Croatian, (4) Vietnamese, and/or (5) Lao, for each of the languages spoken in the provider's office. Press Enter ***twice*** to update the field. Leave this field blank if English is the only language or if the language spoken is not one of the five identified.
e. Press PF2 for the Provider Master File (PMF) for the claim type entry. Tab to the claim types field. Add "T" and press enter. This field allows the provider to receive a $2.00 per member per month administrative fee in addition to any fee-for-service charges the provider may bill.
    1. This claim type is not added for FQHC.
f. Press PF3 for the Provider Master File (PMF) screen where the final MediPASS provider information will be updated.

g. Tab to the MPASS field and enter a "Y"
h. Bypass the DATE field as this field will automatically update with the date information is added to this screen.

i. Tab to the MAX field and enter the number of members the provider has agreed to accept:
    1. 1-1500 for practitioners
    2. 1-2400 for Rural Health Clinic and FQHC.
j. Bypass the CURR field, as this field will update nightly with the number of members who have either been assigned or selected this provider.
k. Tab to AGES and enter the ages served by the provider. Minimum and maximum ages must be entered.
    1. If the provider will accept any ages, enter 0 and 99.
l. Tab to SEX field and enter:
    1. "F" for female only
    2. "M" for male only
    3. "B" for both female and male
m. Tab to CUR/NEW and enter:
    1. "C" if the provider wants only current patients enrolled for MediPASS
    2. "B" if the provider will accept both new and current patient for random assignment
n. Tab to the MPASS-PHN field and enter the area code followed by the 24-hour telephone number the provider has indicated on their agreement.
o. Tab to the MPASS-FEE field and enter a "Y" (unless if the provider is a Federally Qualified Health Center FQHC). An FQHC does not receive the $2.00 administrative fee.
p. Tab to the COUNTIES field and enter the provider's county of residence in the first field, followed by any contiguous counties the provider has noted on the agreement.
    1. It is very important that the provider's county of residence be entered in the first location as the enrollment algorithm for assigning members is tied to this first county location.
    2. It is very important that members are only assigned to a provider in the member's county of residence.
q. Tab to the PLAN-TYPE field and enter a "Z" which indicates MediPASS.
r. Tab to the VEND-ID field and enter a "99" which also indicates MediPASS.
s. Once all of the information noted above has been entered into the Provider Master File (PMF), press *Enter*. MMIS validates the information.
t. If all of the information is correct, press *Enter* again and all of the information entered will be updated in the provider file.
u. If the information is not correct, the retype the incorrect field. Press enter ***twice*** to update.

Step 8: Enter the information from IHAWP Agreement into the Provider Master File in MMIS.

a. Select application (9) Provider Subsystem form the Iowa Medicaid Management Information System on Line Applications (MMIS)

b. Enter option "C" in the Provider Master File to update the provider's record. This function can only be done by those staff members with special authority update MMIS.

c. Tab down to the provider number field and enter the provider's seven-digit Medicaid legacy number. Press Enter.

d. Tab to the "LANG" and enter values of (1) Spanish, (2) Bosnian, (3) Serb/Croatian, (4) Vietnamese, and/or (5) Lao, for each of the languages spoken in the provider's office. Press Enter twice to update the filed. Leave this field blank if English is the only language or if the language spoken is not one of the five identified.

e. Press PF2 for the Provider Master File (PMF) for the claim type entry. Tab to the claim types field. Add "T" and press enter. This field allows the provider to receive a $4.00 per member per month administrative fee in addition to any fee-for-service charges the provider may bill. This claim type is not added for FQHC.

f. Press PF3 for the Provider Master File (PMF) screen where the final I-HAWP provider information will be updated.

g. Tab to the IHAWP field and enter a "Y"

h. Bypass the DATE field as this field will automatically update with the date information is added to this screen.

i. Tab to the MAX field and enter the number of members the provider has agreed to accept. This number can be anywhere from 1-1500 for practitioners, 1-2400 for Rural Health Clinic and FQHC.

j. Bypass the CURR field, as this field will update nightly with the number of members who have either been assigned or selected this provider.

k. Tab to AGES and enter the ages served by the provider. Minimum and maximum ages must be entered. If the provider will accept any ages, enter 0 and 99.

l. Tab to SEX field and enter and "F" for female only, "M" for male only, or a "B" for both female and male.

m. Tab to CUR/NEW and enter a "C" if the provider wants only current patients enrolled for I-HAWP or a "B" if the provider will accept both new and current patient for random assignment.

n. Tab to the MPASS-PHN field and enter the area code followed by the 24-hour telephone number the provider has indicated on their agreement.

o. Tab to the MPASS-FEE field and enter a "Y" (unless if the provider is a Federally Qualified Health Center FQHC). An FQHC does not receive the $2.00 administrative fee.

p. Tab to the COUNTIES field and enter the provider's county of residence in the first field, followed by any contiguous counties the provider has noted on the agreement. It is very important that the provider's county of residence be entered in the first location as the enrollment algorithm for assigning members is tied to this first county location. It is very

important that members are only assigned to a provider in the member's county of residence.

q. Tab to the PLAN-TYPE field and enter a "Z" which indicates Managed Care.

r. Tab to the VEND-ID field and enter a "99" which also indicates Managed Care.

s. Once all of the information noted above has been entered into the Provider Master File (PMF), press *Enter*. MMIS validates the information.

- If all of the information is correct, press *Enter* again and all of the information entered will be updated in the provider file.
- If the information is not correct, then retype the incorrect field. Press enter twice to update.

v. Step 8. If the information entered was for IHAWP proceed to step 9.

Step 9: Enter information in the New I-HAWP spreadsheet.This spreadsheet can be found in the PROSERV share drive, MHC folder, IHAWP folder, IHAWP new enrolls.

Step 10: Enter information in the New MediPASS spreadsheet.

a. This spreadsheet can be found in the PROSERV share drive, MHC folder, MPASS new enrolls.

Step 11: Notify Member Services

a. Email the Member Services Supervisor of the name and provider number of the new provider so an updated daily provider listing can be distributed to member service phone center staff.

Step 12: Generate letter and mail to new patient manager.

a. A welcome letter will be generated by the system overnight and delivered the next morning to the Outreach team. An Outreach Coordinator then mails the welcome letter to the MediPASS provider. Included with the letter will be the following:
    1. MediPASS Procedure Guide A
    2. A member "Your Choice booklet"
    3. A sample of a member's MediPASS medical card

Forms/Reports:

IME Operational Procedures MediPASS Agreement
New MediPASS Providers

RFP References:

6.4.6.3.3.a

Interfaces:

OnBase
Core - As new providers are enrolled into the Iowa Wellness Plan or MediPASS Program, a MMIS generated Welcome letters will be mailed by the core.
Providers

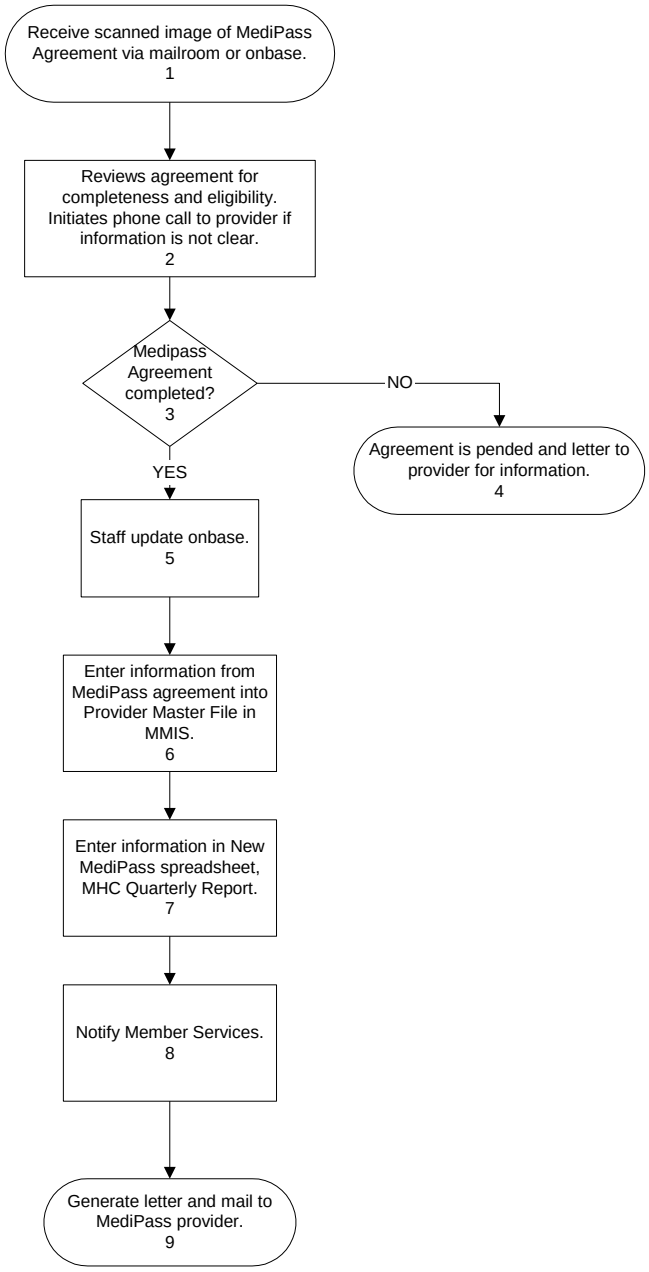
MMIS - Providers who are Managed Care Patient Managers must sign either a Iowa Wellness Plan or MediPASS Provider Agreement in order to become a Patient Manager. In their Provider Master File, we enter the number of patients they agree to serve, the counties they agree to serve, and any restrictions such as patient age or gender, and/or assignment restrictions

Attachments:

Process Map
IME Operational Procedures MediPASS Agreement
IME Operational Procedures MediPASS Outreach Recruitment Letter
IME Operational Procedures MediPASS Welcome Letter
IME Operational Procedures MMIS PMF Screen 3 Screen Shot
New MediPASS Providers

MEDIPASS PROVIDER AGREEMENTS

Education and Outreach Coordinators



IME Operational Procedures MediPASS Agreement

Iowa Department of Human Services
AGREEMENT FOR PARTICIPATION AS A PATIENT MANAGER
IN THE IOWA MEDICAID PATIENT ACCESS TO SERVICE SYSTEM (MediPASS)

This agreement is entered into by the Iowa Department of Human Services (hereinafter referred to as the Department) and the individual provider or the group practice or clinic listed in section XIV of this agreement (hereinafter referred to as the patient manager or PM). This agreement outlines the duties and responsibilities of the parties and shall continue in force until amended by the Department pursuant to section XII or terminated by either party pursuant to section XIII. Renegotiation is not allowed.

I. STATEMENT OF PURPOSE AND LEGAL AUTHORITY

The Department of Human Services contracts with physicians (doctors of medicine and osteopathy), advanced registered nurse practitioners, federally qualified health centers, rural health clinics and with group practices or clinics participating in the Iowa Medical Assistance Program (Iowa Medicaid) for the provision of primary care and the management of other health care needs through appropriate referral and authorization for specified Iowa Medicaid covered services, for selected Iowa Medicaid recipients who may select, or be assigned to, the contractor. This agreement describes the terms and conditions of participation in the program and the responsibilities of the parties entering into the agreement.

The Iowa Medicaid Patient Access to Service System (hereinafter referred to as MediPASS) is a primary care patient management system implemented in accordance with Title XIX of the Social Security Act and is subject to the provisions of the Iowa Administrative Code. This agreement shall be construed as supplementary to the usual provider agreement entered into for participation in the Iowa Medical Assistance Program and all provisions of that agreement shall remain in full force and effect, except to the extent superseded by the specific terms of this MediPASS agreement. The participating Iowa Medicaid provider agrees to abide by all existing laws, regulations, rules, and procedures applicable to the MediPASS program and Iowa Medicaid participation.

II. DEFINITIONS

A. “Cold-call marketing” is any unsolicited personal contact by the PM with a potential enrollee for the purpose of marketing.
B. “Covered services” are Iowa Medicaid covered services that require authorization from the patient manager in order to be payable by Iowa Medicaid. Those services are specified in Section VII B of this agreement.
C. “Emergency medical condition” is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:
   (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
   (2) Serious impairment to bodily functions; or
   (3) Serious dysfunction of any bodily organ or part.
D. “Emergency services” are covered services that are:
   (1) Furnished by a provider qualified to furnish the services under Iowa Medicaid; and
   (2) Needed to evaluate or stabilize an emergency medical condition.
E. “Enrollee” is a covered eligible who has been enrolled with or assigned to a patient manager.
F. “Enrollment Broker” is an agent of the state agency empowered to perform the enrollment function.
G. “Exempt services” are Iowa Medicaid covered services that do not require authorization from the patient manager in order to be payable by Iowa Medicaid.

H. "Grievance" is a complaint expressed verbally or in writing by an enrollee or Medical provider relative to services received or provided under MediPASS.
I. "Managed health care" is the coordinated delivery of health care managed by a designated health care provider responsible for directing or monitoring such care.
J. "Marketing" is any communication, from the PM to a Medicaid recipient who is not enrolled with the PM, that can reasonably be interpreted as intended to influence the recipient to enroll with the PM, or either to not enroll in, or to disenroll from, another PM or other Medicaid managed care provider.
K. "Marketing materials" are materials that--
   (1) Are produced in any medium, by or on behalf of the PM; and
   (2) Can reasonably be interpreted as intended to market to potential enrollees.

However, "marketing materials" does not include materials directed at compliance with periodicity schedules for care or reminders of appointments.

L. "Medical service area" is the recipient's county of residence and the contiguous counties whether in state or out of state.
M. "Patient management" is a managed health care option in Iowa Medicaid in which an individual provider is selected by or assigned to a recipient to provide medical services on a fee-for-service basis and managed health care services including monitoring appropriate utilization and authorization of payment for covered services.
N. "Patient manager" or "PM" is the contracted provider who agrees to accept the terms of this agreement and includes any of the contracted provider's employees, affiliated providers, agents, or contractors
O. "Potential enrollee" means an Iowa Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program but is not yet an enrollee of a specific managed care program.

III. PARTIES, RELATIONSHIPS, AND INTERESTS

A. The parties to this agreement are the Iowa Department of Human Services, the individual provider or the clinic or group practice identified as the PM in section XIV, and each physician, nurse practitioner, and physician's assistant cosigning this agreement in section XIV, part C.
B. This agreement is not transferable.
C. The PM shall notify the Department, within thirty days of such an event, of all changes in licensure, address, practice, or any other factor that may affect participation in MediPASS.
D. FFP is not available for amounts expended for providers excluded by Medicare, Medicaid, or S-CHIP, except for emergency services. The PM will comply with the following regarding affiliations with individuals debarred by federal agencies:
   (a) The PM will not knowingly have a relationship of the type described in paragraph (b) below with the following:
      1. An individual who is debarred, suspended, or otherwise excluded from participating in pro-curement activities under the Federal Acquisition Regulations System (Title 48, Code of Federal Regulations) or from participating in non-procurement activities under regulations issued under Federal Executive Order No.12549 or under guidelines implementing Executive Order No. 12549; or
      2. An individual who is an affiliate, as defined in the Federal Acquisition Regulations System, of a person described in paragraph (a)(1).
   (b) The relationships described in this paragraph are the following:
      1. a director, officer, or partner of the PM;
      2. a person with beneficial ownership of five percent or more of the PM's equity; and
      3. a person with an employment, consulting, or other arrangement with the PM for the provision of items and services that are significant and material to the PM's obligations under this agreement.
E. Officials, employees, and representatives of the Department of Human Services and its contractors with responsibilities relating to agreements with PMs and/or the default enrollment process shall not have any interest in enrollment of Iowa Medicaid recipients into the MediPASS program with any specific PM. The PM shall report to the Department any such potential conflicts.

IV. ENROLLMENT AND RE-ENROLLMENT

Enrollment and re-enrollment of recipients shall occur in accordance with the following provisions:

A. Enrollment will be limited to 1,500 enrollees for each individual patient manager or each provider serving as a patient manager in a clinic or group practice.
   1. The enrollment limit may be raised by 300 for each nurse practitioner or physician's assistant employed full time by the PM.
   2. The enrollment limit may be waived in extraordinary circumstances if requested by the PM. The decision to raise the limit will be made on an individual basis and will be solely at the discretion of the Department.

B. The PM may designate in section XIV of this agreement an enrollment maximum below the limit in paragraph A. The PM may revise that enrollment limit once every six months with sixty days advance notice to the Department. If the PM decreases its enrollment limit to a number which is less than its current enrollment, the PM must continue to serve those recipients already enrolled with it until normal disenrollments put the PM's enrollment below the new maximum.

C. The PM shall specify the counties served at the PM's sites in section XIV so as to assure that enrollment is restricted to those who reside sufficiently near to the PM delivery site so that access is available in a reasonable time using available and affordable modes of transportation.

D. Enrollments and re-enrollments shall occur through the enrollment broker as follows:
   1. Potential enrollees as determined by the Department will be sent information regarding managed health care options available and will be allowed to choose between them. Potential enrollees choosing patient management will be given an opportunity to select a patient manager from a list of available providers serving their county. The enrollment broker will assure that potential enrollees have sufficient information before enrolling to make an informed choice of provider.
   2. If the potential enrollee fails to make a selection of managed health care option, a default enrollment selection will be made based on history, prior enrollment, or an equitable distribution between PMs and HMOs available and in accordance with Iowa Administrative Code 441—Chapter 88. Potential enrollees choosing or assigned to patient management who do not make a selection of patient manager shall be assigned to a patient manager based on enrollment history, an algorithm determined by the Department, and appropriate provider specialty.
   3. An enrollee who is disenrolled solely because he or she loses Iowa Medicaid eligibility for a period of 2 months or less will be automatically re-enrolled with the same PM.
   4. The enrollment broker shall provide all notices, informational materials, and instructional materials relating to enrollment provided to enrollees and potential enrollees. Such notices and materials shall be provided in a manner and format that may be easily understood.
   5. Within a reasonable time after notice of enrollment with the PM, the enrollment broker shall furnish the following to each enrollee:
      (a) A medical assistance identification card issued to each enrollee with the name and twenty-four hour telephone number of the patient manager.
      (b) The names, locations, telephone numbers of, and non-English languages spoken by current providers in the enrollee's service area, including identification of providers that are not accepting new patients.
      (c) Any restrictions on the enrollee's freedom of choice among providers.
      (d) Enrollee rights and protections under this agreement and applicable law.
      (e) Information on grievance and appeal procedures.
      (f) Benefits available including family planning services.
      (g) Procedures, including authorization requirements, for obtaining benefits, including family planning services.
      (h) How to access emergency care.
      (i) What constitutes emergency care.
      (j) The right of the enrollee to use any hospital for emergency services.
   6. The enrollment broker shall provide written notice to enrollees of any change the

Department deems significant in the information specified in "5" above, at least 30 days prior to the intended effective date of the change.

7. The enrollment broker shall provide the PM with a list of enrollees and potential enrollees each month.

E. Patient managers may discuss enrollment with their current patients and may assist recipients in completing enrollment forms.

F. The PM shall:

1. Accept enrollees, including voluntary and mandatory assignments, in the order in which they are enrolled, up to the limits set under this agreement.
2. Treat recipient enrollment as voluntary unless required by the State.
3. Not discriminate against individuals enrolled based on health status or need for health care services.
4. Not discriminate against individuals enrolled on the basis of age, race, creed, color, sex, physical or mental disability, national origin, religion, or political affiliation nor use any policy or practice that has the effect of such discrimination.

V. DISENROLLMENT

The PM shall provide primary care and management of other health care needs to all enrollees until disenrollment pursuant to the following provisions.

A. Requests for disenrollment by an enrollee or the PM shall be processed by the Department or the enrollment broker.

B. An enrollee or an enrollee's representative may request disenrollment by submitting an oral or written request to the Department or the enrollment broker:

1. Without cause, at the following times:
   a. During the 90 days following the date of the enrollee's initial enrollment with PM, or the date of notice of the enrollment, whichever is later.
   b. At least once every 12 months thereafter.
   c. Upon automatic reenrollment under section IV D 3 of this agreement, if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.
   d. When the Department imposes the intermediate sanction of granting enrollees the right to terminate enrollment without cause.
2. At <u>any</u> time for any of the following causes:
   a. The enrollee moves out of the PM's service area.
   b. The PM does not, because of moral or religious objections, provide the service the enrollee seeks.
   c. Other reasons, including but not limited to, poor quality of care, lack of access to covered services, or lack of access to providers experienced in dealing with the enrollee's health care needs.

C. The Department shall give all enrollees and enrollees representatives written notice of disenrollment rights at least 60 days before the start of each enrollment period.

The Department shall also give written or oral notice of disenrollment rights to any enrollee or representative upon receipt of any complaint from the enrollee or representative. The PM shall refer any and all requests for disenrollment from an enrollee or representative to the Department or the enrollment broker.

D. The Department or enrollment broker will approve or disapprove a request for disenrollment by an enrollee or representative based on the following:

1. Reasons cited in the request.
2. Any Information provided by PM at the Department or enrollment broker's request.
3. Any of the reasons specified in V B 2.

E. The PM may request disenrollment of an enrollee as follows:

1. Requests for disenrollment by the PM must be submitted to the Department or enrollment broker in writing and must specify one or more of the following reasons for disenrollment:
   a. failure to develop a provider/patient relationship;
   b. the enrollee has moved out of the PM's service area;
   c. the PM does not, because of moral or religious objections, provide the service the enrollee seeks; or
   d. the continued enrollment of the enrollee seriously impairs the PM's ability to furnish services to either the enrollee or other enrollees.

2. Requests for disenrollment by the PM must include a written assurance that the disenrollment is being requested for the reason or reasons stated and not for any other reason.
3. The PM will not request disenrollment based on the recipient's health status or need for health care services, because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the PM's ability to furnish services to either the enrollee or other enrollees).
4. The PM will not request disenrollment solely on the basis of age, race, creed, color, sex, physical or mental disability, health status, national origin, religion, or political affiliation.

F. The effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the enrollee or PM files the request. If the Department or enrollment broker fails to make the determination within this timeframe, the disenrollment is considered approved.

G. An enrollee who requested disenrollment and is dissatisfied with a Department or enrollment broker determination that there is not good cause for disenrollment may appeal to the Department pursuant to 441 Iowa Admin. Code ch. 7.

VI. MARKETING

Any marketing activity by the PM shall be in compliance with the following requirements:

A. Any marketing by the PM, including any marketing materials, must be approved by the Department prior to any marketing activity. Requests for approval must include a written marketing plan, any materials to be used, and a written assurance that the marketing will be accurate and will not mislead, confuse, or defraud the recipients or the Department. For this purpose, statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that--

(i) a recipient must enroll with the PM in order to obtain benefits or in order to not lose benefits; or

(ii) the PM is endorsed by the Department, the Centers for Medicare & Medicaid Services, the Federal or State government, or similar entity.

B. The PM shall distribute any marketing materials to its entire service area as indicated in this agreement.

C. The PM shall comply with the information requirements of VII S-W and XII to ensure that, before enrolling, the recipient receives, from the PM or the State, the accurate oral and written information he or she needs to make an informed decision on whether to enroll.

D. The PM shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

E. The PM shall not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

VII. RESPONSIBILITIES OF THE PATIENT MANAGER REGARDING PROVISION OF MANAGED HEALTH CARE, RECORDS, REVIEW, AND PATIENT RELATIONS

The patient manager agrees to:

A. Provide managed health care to all enrollees by providing necessary and appropriate primary health care and providing or referring the enrollee to other providers of medical care, as medically necessary and appropriate, for those services provided under IAC 441- Chapters 78 and 84. Any services provided by the PM will be consistent with the licensure and certification of the PM. Referrals shall occur in accordance with accepted practice in the medical community. The PM shall refer any pregnant woman seeking enhanced services to a Maternal Health Center and make every reasonable effort to refer patients eligible for early and periodic screening, diagnosis, and treatment services to an appropriate source for this service or provide the services and appropriate follow-up care or referral for conditions identified during screening. No special referral form is required. The PM is responsible for monitoring and coordinating all medical care. Arrangements for referrals to other practitioners must be sufficient in

numbers of available practitioners so that services provided can be furnished to enrollees promptly and without compromising quality of care. The PM understands that the Department will not make payment for any service provided by a provider not participating in the Iowa Medicaid program, except for emergency services.

B. Pre-authorize payment as medically necessary when referring the patient to another provider, in the manner prescribed by the Department in provider manual, for the following services: inpatient hospital, outpatient hospital, home health, physician (except ophthalmology), clinic (including Rural Health Clinics, Maternal Health Clinics, Genetic Consultation Centers Birthing Centers and Ambulatory Surgical Centers), laboratory and x-ray, medical supplies, physical therapy, audiology, rehabilitation agency, nurse midwife, nurse practitioner, podiatry, nurse anesthetist and psychiatric. Authorization for payment shall also be made after the fact for services received in an emergency and for urgent care received when the PM could not be reached. After the fact authorization for payment for emergency services shall not be denied, regardless of where the service is provided, by whom the service is provided, whether the PM referred the enrollee to the provider, or any other factor. The PM shall not deny authorization for emergency services obtained when the PM or a representative of the PM instructs the enrollee to seek emergency services. However, the PM is not obligated to authorize payment for services that do not meet the definition of emergency services when they are provided without consulting the PM.
C. Request or conduct pre-procedure and pre-admission reviews according to criteria established by the Department and the peer education and review committee.
D. Provide or arrange for primary care coverage for service, consultation, or approval of referrals twenty-four hours per day, seven days per week.
E. Make a referral for a second opinion if requested by the enrollee when surgery has been recommended. Treatment subsequent to the second opinion shall be rendered by the PM or through referral made by the PM.
F. Review utilization and cost reports provided by the Department as prescribed in provider manual and advise the Department of any errors, omissions or discrepancies of which the provider may be aware.
G. Maintain a unified patient medical record for each enrollee that contains at a minimum: identification of the patient as a MediPASS enrollee; name, state identification number, age, sex, and address of the enrollee; documentation of services provided, including where and by whom provided; and medical diagnosis, treatment, therapy, and drugs prescribed or administered.
H. Document in the enrollee's record all authorizations for covered services provided by other providers.
I. Respond to request for verification that specific services paid were actually authorized by the PM.
J. Provide the Department or its agent and the Centers for Medicare & Medicaid Services with access (including on-site inspections, review, and copying) to all records relating to the provision of services under this agreement.
K. Allow enrollees to request and receive a copy of their medical records, and to request that they be amended or corrected, as specified in title 45, Code of Federal Regulations, section 164.526.
L. Retain all records for at least 5 years from the date of creation, 3 years from the date final payment is made, or until any litigation, claim, financial management review, or audit has been resolved and final action taken, whichever period is longer.
M. With the patient's permission, transfer the medical records of all former enrollees at the request of the Department, its agent, the former enrollee, or the former enrollees' new patient manager.
N. Provide for evaluation of services performed and for independent audit and inspection of the PM's records.
O. Allow the State or Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness,

or timeliness of services and reasonableness of their costs.

P. Treat each managed care enrollee with respect and with due consideration for his or her dignity and privacy.

Q. Provide each enrollee information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

R. Provide each enrollee the opportunity to participate in decisions regarding his or her health care, including the opportunity to refuse treatment.

S. Provide written materials in easily understood language and format and in alternative formats that take into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

T. Inform all enrollees and potential enrollees that information is available in alternative formats and how to access those formats.

U. Make its written information available in the prevalent non-English languages identified by the Department in its service area.

V. Make oral interpretation services available free of charge to each potential enrollee and enrollee for any non-English language.

W. Notify enrollees that oral interpretation is available for any language, that written information is available in prevalent non-English languages, and of how to access those services.

X. Allow each enrollee to exercise his or her rights, and not treat any enrollee adversely due to the exercise of the enrollee's rights.

Y. Not use any form of restraint or seclusion of an enrollee as a means of coercion, discipline, convenience, or retaliation.

Z. Comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees.

AA. Comply with any other applicable Federal and State laws (such as Title VI of the Civil Rights Act of 1964, etc.) and other laws regarding privacy and confidentiality.

VIII. RESPONSIBILITIES OF THE DEPARTMENT IN SUPPORT OF PATIENT MANAGEMENT

The Iowa Department of Human Services agrees to:

A. Provide the PM with periodic cost and utilization reports in order to enhance managed health care and recipient education efforts and to allow PMs to compare peer utilization levels.

B. Establish a managed health care advisory committee to examine peer utilization and establish standards for acceptable levels of utilization, to consult and make recommendations for action on quality of care issues and to make recommendations for corrective action measures to take with PMs when utilization of quality of care deficiencies are identified.

C. Ensure that enrollments, disenrollments, requests for exception to policy, and grievances are processed in a timely fashion.

D. Establish protocols for PMs to use in authorization of medical services in routine, urgent, and emergent situations; for reviewing and acting upon utilization review reports; and for other procedures necessary for the administration of MediPASS. These protocols will be created in cooperation with the managed health care advisory committee and will be published in the form of Department of Human Services provider manual.

E. Establish a grievance procedure in order to resolve concerns of recipients or providers relative to services received or provided under MediPASS.

IX. PAYMENT

The Iowa Department of Human Services agrees to:

A. Pay the PM a management fee of $2.00 monthly for each enrolled recipient, subject to a maximum monthly fee for each provider providing patient management of $3,000.00, regardless of the number of recipients enrolled with the PM.

B. Pay the PM for medical services covered under the Iowa Medicaid program provided to enrollees according to the fee-for-service reimbursement system in place in the Iowa Medicaid program.

X. COMPLIANCE WITH OTHER LAWS

A. The Department and the PM shall comply with all applicable Federal and State laws and regulations including title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

B. The PM shall comply with the following:
- the Equal Employment Opportunity Act ;
- the Byrd Anti-Lobbying Amendment to
- the Copeland Anti-Kickback Act;
- the Davis-Bacon Act; and
- the Debarment and Suspension requirements

C. By signing this agreement, the PM states that federal funds have not been used for lobbying in connection with this agreement.

XI. INTERMEDIATE SANCTIONS

The Department may impose intermediate sanctions on the PM (short of termination of this agreement) pursuant to the following:

A. The intermediate sanctions that the Department may impose under this agreement are the following:
   (1) Recovery of patient management fees paid
   (2) A period of probation, subject to a plan of corrective action.

B. Intermediate sanctions other than appointment of temporary management may be imposed if the Department determines that the PM has acted or failed to act as follows:
   (1) has failed substantially to provide medically necessary services that the PM is required to provide, under law or under this agreement, to an enrollee;
   (2) has acted to discriminate among enrollees on the basis of their health status or need for health care services, including termination of enrollment (except as permitted under section V E) or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future medical services;
   (3) has misrepresented or falsified information furnished to the Centers for Medicare & Medicaid Services or to the Department;
   (4) has misrepresented or falsified information furnished to an enrollee, potential enrollee, or health care provider;
   (5) has distributed, directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information;
   (6) has otherwise failed to adhere to terms of this agreement, including but not limited to failure to properly notify the Department of changes in status or failure to maintain proper records and documentation; or
   (7) has violated any of the other requirements of 42 United States Code sections 1396b(m), 1396d(t)(3), 1396u-2, or any implementing federal regulations (grounds for sanctions listed in A (5)-(7) only).

C. Before imposing any intermediate sanction the Department will give the PM written notice that explains the following:
   (1) the basis and nature of the sanction; and
   (2) the date the sanction will take effect, which shall be at least ten (10) days following notification.

D. The Department retains the authority to impose sanctions against the PM under 441 Iowa Admin. Code 79.2. Nothing in this agreement prevents the Department from exercising that authority.

XII. AMENDMENT

Amendments or changes to this agreement will be made only by the Department after consultation with representatives of affected providers and with at least thirty days advance notice. Such revisions become part of this agreement upon notification of the PM. Upon notice of amendment, the PM may terminate their participation in MediPASS as described in section XII A of this agreement.

XIII. TERMINATION

Termination of this agreement is governed by the following provisions:

A. The PM may terminate the contract and a clinic or group practice may remove a provider from a clinic or group practice contract by providing the Department with written notice sixty (60) days in advance of the desired date of termination or removal, to allow the department time to enroll MediPASS patients with other patient managers or an HMO. The PM shall make a good faith effort to notify all enrollees in writing within 15 days when a contracted PM intends to terminate participation in MediPASS or remove a provider from the contract. The PM shall continue to provide patient management to enrollees until they can be reenrolled with another patient manager or HMO.

B. The Department may terminate this agreement with 60 days advance notice if:
   1. the Department has imposed any sanction on the PM as a provider of Iowa Medicaid services under 441 Iowa Admin. Code section 79.2;
   2. the managed health care advisory committee has recommended termination of the agreement after opportunity for corrective action has been unsuccessful or rejected by the PM;
   3. the Department determines that the PM has failed to carry out the substantive terms of this agreement; or
   4. the Department determines that the PM has failed to meet applicable requirements of 42 United States Code section 1396b(m), 1396d(t), or 1396u-2

C. Notice of termination pursuant to paragraph B shall be in writing, shall state the reason for termination, and shall give appeal rights pursuant to 441 Iowa Admin. Code chapter 7. A timely appeal pursuant to 441 Iowa Admin. Code chapter 7 will stay termination of the agreement pending a final decision.

D. The agreement shall automatically terminate upon death or retirement of the PM, bankruptcy, dissolution or sale of the PM's practice.

E. The Department may terminate the agreement with the PM without advance notice in situations such as, but not limited to, the death of the PM, the PM having left medical practice (permanently or for an extended or indefinite temporary period), moved from the counties served as designated in section XIV, or been removed as a Iowa Medicaid provider.

F. After the Department gives notice that it intends to terminate the agreement under paragraph B, D, or E, the Department may:
   1. Give the PM's enrollees written notice of the Department's intent to terminate the contract.
   2. Allow enrollees to disenroll immediately without cause.

XIV. PATIENT MANAGEMENT PROVIDER ENROLLMENT INFORMATION

THE PROVIDER MUST CHECK THE APPROPRIATE BOX IN PART A OR PART B, TYPE OR PRINT ALL INFORMATION FOR THE APPROPRIATE OPTION AND

COMPLETE PART C, IF APPLICABLE

A. Individual Practice

❑ I am an individual provider electing to contract with the Department of Human Services as a MediPASS patient manager. Each physician, nurse practitioner and physician's assistant employed by me who will be participating in MediPASS patient management will cosign this agreement in Part C of this Section and thereby be made a party to it. The following are the sites at which I practice and the maximum number of enrollees desired:

Name, Degree	
Individual Iowa Medicaid Provider #	Max. # of Enrollees
Office Name if any	
Address	
City, State and Zip	
Counties Served at This Site (*See Instructions Below and section IV C)	
Telephone Number for 24 Hour Availability	
Individual Provider # for Second Practice Site	Max. # of Enrollees
Name of Second Office, if any	
Address of Second Practice Site	
City, State and Zip of Second Practice Site	

B. Clinic or Group Practice

❑ I am an authorized representative of a clinic or group practice electing to contract with the Department of Human Services for employees or partners of the clinic or group to serve as MediPASS patient managers. Each physician, nurse practitioner and physician's assistant employee who will be participating in MediPASS patient management will cosign this agreement in Part C of this section and thereby be made a party to it. The following is identifying information for the clinic or group practice:

Name of Authorized Representative	
Title of Authorized Representative	
Clinic Name	
Clinic Iowa Medicaid Provider Number	Clinic Specialty
Site Name, if Different Than Clinic Name	
Address	
City, State and Zip	
Counties Served at This Site (*See Instructions Below and section IV C)	
Telephone Number for 24 Hour Availability	
Second Site Name if any	
City, State and Zip of Second Site	

Counties Served at This Site (*See Instructions Below and section IV C)	Counties Served at This Site (*See Instructions Below and section IV C)
See attached sheet for complete listing of counties that are currently in the Iowa Medicaid Managed Health Care Program, or are in the process of having the Iowa Medicaid Managed Health Care Program implemented in their county.	***Mode of payment selected must be the same as is used for payment of fee-for-service claims***

GO TO PART C ON BACK OF THIS SHEET.

C. Provider Information and Co-signatures for physicians, Nurse Practitioners and Physician's Assistants Participating in Patient Management Under This Agreement

Name of site: _____

(Clinics must complete a separate Section C for each clinic site)

COMPLETE THE DATA ELEMENTS FOR ALL PARTICIPANTS AS FOLLOWS:

a. TYPED NAME, DEGREE
b. MAXIMUM NUMBER OF ENROLLEES
c. IOWA MEDICAID PROVIDER NO.
d. PATIENT CARE HOURS/WEEK THIS SITE
e. SPECIALTY
f. SIGNATURE
g. DATE SIGNED
AGE RANGE TREATED _____ - _____
GENDER TREATED M / F – BOTH
FOREIGN LANGUAGES SPOKEN _____

1.	a.		b.		
	c.		d.	e.	
	f.		g.		
2.	a.		b.		
	c.		d.	e.	
	f.		g.		
3.	a.		b.		
	c.		d.	e.	
	f.		g.		
4.	a.		b.		
	c.		d.	e.	
	f.		g.		
5.	a.		b.		
	c.		d.	e.	
	f.		g.		

COMPLETE ADDITIONAL SHEETS, AS NECESSARY, IN THE SAME FORMAT. PAGE _____ OF _____

XV. SIGNATORIES

DEPARTMENT OF HUMAN SERVICES.	**MediPASS PROVIDER**
Signature of Authorized Official	Signature of Authorized Official
Typed Name	Typed Name
Title	Title
Date	Date

POLICY ON NONDISCRIMINATION Federal, state and local laws and regulations prohibit discrimination on the basis of race, color, national origin, sex, religion, creed, age, mental or physical disability, or political belief by the Iowa Department of Human Services or any of its vendors supplying goods or services to recipients for which direct payment is made by the Department for furnishing the services.

IME Operational Procedures MediPASS Outreach Recruitment Letter

Iowa
Department
of
Human Services

DATE

PROVIDER NUMBER

PROVIDER
ADDRESS 1
ADDRESS 2
CITY, STATE ZIP CODE

RE: MediPASS Participation

Dear Provider Name:

Thank-you for your interest in becoming a MediPASS Patient Manager in the Iowa Medicaid Program. As a MediPASS Patient Manager, you will be part of a program that assures that Medicaid members get the medical care they need in the most appropriate care setting.

Enclosed you will find a MediPASS Provider Agreement. Please take a few moments to complete the MediPASS Provider Agreement and return the signed original to:

Iowa Medicaid Enterprise
Provider Services – MediPASS Outreach
PO Box 36450
Des Moines, IA 50315

If you have any questions, please contact one of our other Provider Outreach staff or me at 515-725-XXXX

Sincerely,

Iowa Medicaid Enterprise
Provider Education and Outreach Unit
Enclosures

IME Operational Procedures MediPASS Welcome Letter

Iowa
Department
of
Human Services

DATE

PROVIDER NUMBER

PROVIDER
ADDRESS 1
ADDRESS 2
CITY, STATE ZIP CODE

RE: MediPASS Participation

Dear Provider Name:

Welcome to the Iowa Medicaid Managed Health Care (MHC) Program and to MediPASS (Medicaid Patient Access to Services System). Thank you for submitting your agreement to participate as a patient manager with the MediPASS Program. Your agreement has been approved by the Iowa Department of Human Services.

As a patient manager, you have become part of an exciting health care program with a proven record of success. Currently, over 90 counties participate in the Medicaid Managed Health Care Program.

Enclosed in this mailing is a packet of materials to assist you in integrating managed care into your practice. These materials include:

1. "Procedure Guide for MediPASS Patient Managers"
2. A copy of the "Your Choice" Managed Health Care Enrollment Booklet
3. A sample copy of the member's pink Medicaid Managed Health Care card

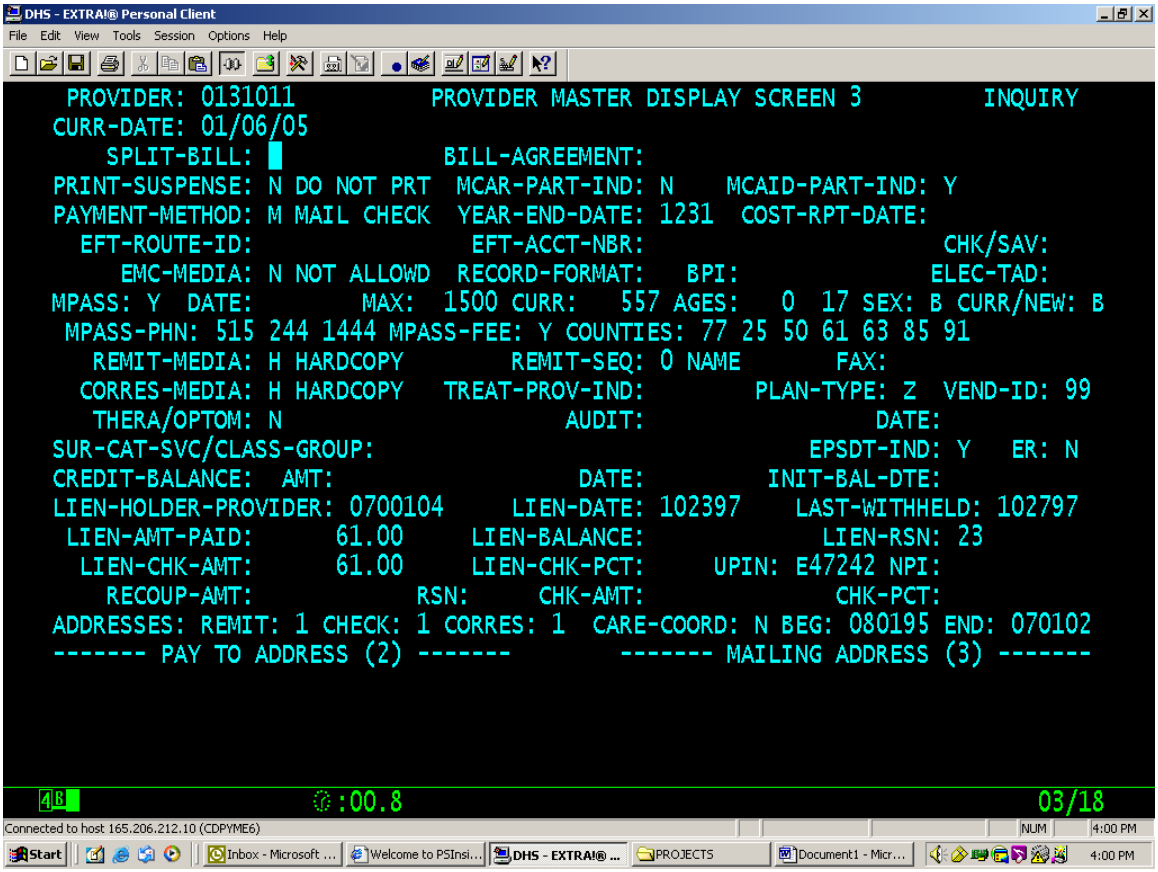
Medicaid members in the Temporary Assistance to Needy Families (TANF), formerly known as ADC and ADC-related groups, are required to select a MediPASS provider as a patient manager. Some members have an additional Managed Health Care option of enrolling with a Health Maintenance Organization (HMO). Hopefully, this information will assist you in responding to questions your patients may have regarding the Medicaid Managed Health Care Program.

If you have questions regarding the Iowa Managed Health Care Programs, please call the IME Provider Outreach staff at 1-800-338-7909 or (515) 725-1004 in the Des Moines area.

Sincerely,

Iowa Medicaid Enterprise
Provider Education and Outreach Unit
Enclosures

IME Operational Procedures MMIS PMF Screen 3 Screen Shot



a. Enter MPASS = Y
b. Enter MAX = The providers maximum enrollees from the MediPASS Agreement
c. Enter AGES =-Member ages served by the provider
d. Enter SEX = F for female only, M for male only, B for both female and male.
e. Enter CUR/NEW = C if the provider only wants current patients enrolled for MediPASS or B if the provider will accept new patients for MediPASS
f. Enter MPASS-PHN = the provider's 24 hour telephone number from the MediPASS Agreement.
g. Enter MPASS-FEE = Y
h. Enter COUNTIES = The counties served from the MediPASS Agreement. Must enter provider's county of residence first.
i. Enter PLAN-TYPE = Z.
j. Enter VEND-ID = 99.
k. Once you have the information in the Provider Master File, press Enter. MMIS validates the information. If all of the information is correct, press Enter again.

New MediPASS Providers

date	provider number	provider name	affiliation	comment